



NATIONAL ASSOCIATION OF WORKSITE HEALTH CENTERS

May 15, 2015

CC: PA: LPD: PR (Notice 2015-16)  
Room 5203  
Internal Revenue Service  
P.O. Box 7604  
Ben Franklin Station  
Washington, DC 20044

**RE: Notice 2015-16 (Excise Tax on High Cost Employer-Sponsored Health Coverage)**  
Submit electronically via [notice.comments@irs.counsel.treas.gov](mailto:notice.comments@irs.counsel.treas.gov) / Subject: Notice 2015-16

Ladies and Gentlemen:

On behalf of the National Association of Worksite Health Centers (NAWHC) I'm pleased to submit the following comments and recommendations regarding IRS Notice 2015-16 related to how onsite clinics should be treated under implementation of the Code Section 4980I, the excise tax created under the Affordable Care Act (ACA).

### **Overview Of NAWHC, The Onsite Clinic Movement And Its Impact**

The Chicago-based NAWHC ([www.worksitehealth.org](http://www.worksitehealth.org)) is the nation's only non-profit, trade association of employer sponsors of onsite and near-site health, fitness, pharmacy and wellness centers. Formed in 2012, NAWHC has identified over 500 public and private employers of all sizes, locations and industries that offer some form of provider-delivered services at the worksite.

NAWHC conducts annual benchmarking surveys, educational programs and networking activities to enable employers to share and compare experiences, information and best practices in the delivery of innovative preventive, medical and wellness services for covered populations.

Based on NAWHC's own studies, as well as national surveys conducted by major consulting firms, academic institutions and research organizations, it's estimated that 20-30% of all employers provide these types of services to their employees. Recent survey information indicates that among employers with 5,000 or more employees, 29% offer a clinic providing primary care services.<sup>1</sup>

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<sup>1</sup> See <http://www.mercer.com/content/mercerglobal/all/en/newsroom/modest-health-benefit-cost-growth-continues-as-consumerism-kicks-into-high-gear.html>.



NATIONAL ASSOCIATION OF WORKSITE HEALTH CENTERS

Many employers also use their clinics to serve dependents, part-time and contract workers, retirees and even other employer groups and the local community. They also serve as a vital component of the community public health system, offering a variety of screening, preventive, wellness and condition management services.

### **Onsite Clinics and the ACA**

Onsite clinics, many called “Health and Wellness Centers,” support the ACA’s objectives of achieving the Triple Aim by:

- Improving the quality of medical care through a rigorous adherence to evidenced-based medicine and use of electronic medical records;
- Reducing the cost of medical care and increasing individual consumerism, through a focus on wellness and prevention, and by offering low or no cost services to their patient populations, while avoiding unnecessary use of local hospital emergency departments;
- Providing increased access to health care coverage and medical services, especially in medical manpower shortage areas; and
- Improving the patient experience, by offering easily accessible, customized and convenient services at the worksite, reducing the need to leave work or spend after hours time to obtain needed care. The onsite clinic providers get to know their worksite population, as well or better than an individual’s primary care physician, and can focus on providing health promotion and treatment options that are most effective.

In addition, employers who sponsor onsite clinics support the ACA’s encouragement of “innovative care delivery models” that serve to evolve existing modes of health care delivery to models that benefit individuals and the their community, the worksite.

Depending on where they are located, employer sponsors of clinics have found that close to 40%-65% of patients using an onsite center don’t have a personal physician making the clinic their sole source of primary care. Subsequently, an onsite clinic can act as a “medical home” that promotes continuity and not fragmentation of health care delivery. As noted above, the facilities often provide care that extends beyond the employee, but to their family as well, a significant benefit, as dependents are often the highest cost group to employers

Due to these attributes, the clinics also improve productivity and reduce unnecessary absenteeism, important goals for employers and the local economy.



NATIONAL ASSOCIATION OF WORKSITE HEALTH CENTERS

Onsite clinics also keep employees healthier and better informed consumers of health care, both which have the beneficial effect of decreasing costs. Onsite immunizations, for instance, increase the rate of immunization among employees and their families, protecting them and the surrounding community against disease and thus, reducing medical expenses.

### **Onsite Clinics And The Excise Tax**

The ACA provision on the excise tax indicated that onsite clinics that offer more than “de minimis” services, essentially first aid care, should be considered part of the applicable benefits and included in the excise tax computations. The law took the term “de minimis” from the IRS Code section related to what was to be excluded from a firm’s COBRA coverage.

That section was written and adopted at a time when onsite clinics were no more than occupational health and first aid stations. Today, NAWHC and other researchers have found that employer clinics offer a diverse set of services beyond first aid. We’re finding that employee populations now have access not only to first aid care, but also acute, primary and condition management services, dental and vision care, pharmacy services, physical and massage therapy, acupuncture, chiropractic care, lab and imaging services, health coaching, wellness and preventive programs and behavioral health services.

As mentioned above, these clinics not only provide essential services to the covered populations, but they often enable patients to gain access to care which is often lacking due to shortages of medical providers in many communities, especially those in rural areas.

The ACA section on the excise tax was never intended to tax medical and other ancillary services delivered by local health care providers who offer these types of services, many of whom are contracted to work in these clinics. Subsequently, it would be inequitable to apply the tax to onsite clinics merely because they are sponsored by employers, and not health care providers.

There are also inconsistencies in how various laws treat onsite clinics. For example, we find that ERISA provides an exception for onsite clinics that offer first aid and injury care, while COBRA regulations offer an exception for onsite services, but only if the care is free and limited to employees, and HIPAA/ACA provide a general exception for onsite medical clinics, but never define what is considered an “onsite clinic.”

We also note that a clinic that is treated as a covered network facility for the purposes of the employer’s health plan is already considered part of that plan, and, subsequently, the clinic should not be double counted in making cost determinations on benefits.



NATIONAL ASSOCIATION OF WORKSITE HEALTH CENTERS

The evidence suggests that employers with more than 1,000 employees or arrangements where multiple employers share clinics, can experience a complete return on investment and decrease overall health plan costs by more than 20% after 3 years.

Finally, determining the actuarial value of onsite clinics is not an exact science, and can be highly subjective, based on the perceptions of value by the employer sponsor or outside entities. As noted above, clinics can improve health, reduce cost, avoid unnecessary care, reduce absenteeism, enhance productivity and increase public health efforts.

Additionally, it is difficult to allocate costs and value of a clinic or to determine how it should be calculated if part of a benefit plan, since employers differ in who is eligible for clinic services: not all employees or covered lives may have access or utilize the services and yet, non-plan participants may have access.

## Recommendations

In light of the above, we recommend that:

1. Onsite clinics offering services beyond de minimis care should be excluded from the excise tax: Employers who sponsor onsite clinics as health and medical settings of care should not be penalized by being required to include the clinic's "value" in the calculation of excise tax. The excise tax was intended to support the objectives and activities of the ACA, not be a disincentive for employers trying to improve health and access to care and reduce the overall cost to individuals. The ACA doesn't tax health care providers for offering these services and neither should it tax an employer's onsite clinic that plays the same role for its covered populations.
2. Employer-sponsors of clinics should receive tax credits and be incentivized for supporting the ACA's Triple Aims: Rather than being taxed for their efforts, the IRS should encourage efforts that promote better health higher quality, patient experiences and health care innovation.
3. The IRS should not create a separate definition of "onsite medical clinic" solely for purposes of Code section 49801: This adds to the complexity and will result in confusion on how employers should comply due to the inconsistency that currently exists within various employer-focused laws and regulations.



NATIONAL ASSOCIATION OF WORKSITE HEALTH CENTERS

4. The “de minimis” term be removed from or redefined in the regulations: The evolution of onsite clinics since the term was first utilized in rules causes its meaning to no longer be relevant to what clinics are doing. Should elimination of “de minimis” not be possible, a broad definition of de minimis onsite medical coverage should be adopted; as such facilities lower, rather than drive, unnecessary utilization.
5. The IRS should define de minimis coverage in a way that does not distinguish between the efforts of large and small employers pursuing strategies that increase the receipt of high-value primary care: While many employers have built cost-effective clinics on their campuses, some smaller employers contract a single nurse to give onsite immunizations or provide routine care in a medical van on a periodic basis.
6. If clinics must be included in the tax, the IRS should not list individual services, but allow a safe harbor for employers who offer services under a specific amount: In determining how to calculate the cost of services, a safe harbor for should be created for employers whose clinic services are valued up to \$650 per employee per year or a percent of the plan cost, i.e. 25%. This is an amount that allows employers with onsite clinics significant flexibility to continue delivering services to their employees without the concern of having to discontinue those services due to the excise tax. There should also be a COLA adjustment provided to this amount.
7. Individuals in a qualified HDHP with a Health Savings Account (HSA) should be allowed to use an onsite clinic under the same cost structure established by the clinic as those not in a qualified HDHP, regardless of where they are in meeting their annual deductible. HDHPs have been shown to increase consumerism, which helps reduce costs - and most employers have or will be adopting a HDHP plan (Bronze / 60% medal value from the Marketplace equivalency). We want people to save for retirement, and Health Savings Accounts are an excellent vehicle for saving for post-retirement medical care expenses (this could take a burden off of the Medicaid system). Requiring people enrolled in a HDHP who have a HSA pay Fair Market Value for onsite clinic services below the deductible is counter productive to helping Americans save money.

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NATIONAL ASSOCIATION OF WORKSITE HEALTH CENTERS

8. In light of the many areas of uncertainty, Treasury and IRS should exercise their discretionary authority to provide an enforcement delay in implementing the imposition of the excise tax until the year 2020.<sup>2</sup> : A delay will allow additional time for all agencies with interpretive and enforcement authority relating to the regulation of onsite medical clinics to analyze the empirical data underlying the arguments referenced above and below. Most notably, a delay in enforcement most assuredly also will delay the steady march towards benefits cutbacks, many of which already are underway and, without a course correction, more will follow.

In sum, the rules developed to implement the excise tax should recognize that onsite clinics advance the ACA and promote the provision of many forms of high value population health management, preventive and wellness services. They represent one of the many innovative ways employers are addressing their organization's health at large and small worksites.

Employers concerned about the excise tax will be faced with a difficult decision if their onsite clinics become a cost addition to their benefits and are wrestling with eliminating their onsite center services that go beyond the current definition of "de minimis" versus eliminating their Health Savings Account benefit offerings. Neither elimination would benefit the employees or the healthcare system.

Thank you for your consideration of these comments and recommendations. I would be pleased to talk or meet with anyone on the topic of onsite clinics and their value. Feel free to contact me at 312-372-9090, 101 or [lboress@worksitehealth.org](mailto:lboress@worksitehealth.org).



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<sup>2</sup> Treasury and IRS previously have exercised discretion to grant administrative flexibility with respect to certain provisions under the ACA. See e.g., the delay relating to imposition of the employer mandate penalty, the delay relating to the imposition of the penalty for failure to transition to the SHOP exchanges, and the delay relating to compliance with the statute's W-2 reporting requirements.